Dental Treatment Authorization

Dear Valued Dental Provider,
As her prenatal care provider, I give my permission for

- *Patient First and Last Name*
- *Patient date of birth*

to receive any needed dental care, at any time during her pregnancy. This includes oral examinations, dental prophylaxis, scaling and tooth planning, extraction, dental radiographs with lead shielding and local anesthetics with epinephrine such as Lidocaine, Bupivacaine, Mepivacaine.

I recommend acetaminophen for pain management after dental procedures. If you must use opioids, please prescribe the lowest dose for the shortest duration (usually less than 3 days).

Please feel free to contact me with any further questions, or if you believe more complex care coordination might be required.

Thank you,

Prenatal Provider signature

Prenatal Provider full name

Prenatal Provider title

Prenatal Provider phone number

Get support and learn more about how you can enhance your prenatal services at:
www.CavityFreeAtThree.org

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Department of Public Health & Environment